

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST JOSEPH HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 BROADWAY FORT WAYNE, IN 46802</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00143446</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 3-12-14</p> <p>Facility Number: 005043</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>St Joseph Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 03/31/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE